Note: Parents must sign either the Consent or the Refuse to Emergency Medical Care.

Medical Alert (known allergies or medical needs)

In Case of Emergency, Notify:

Name_____**Phone**_____

Address_____**Relationship**_____

Name of Secondary Contact_____**Phone**_____

Address_____**Relationship**_____

If unsuccessful attempts have been made to contact parents or emergency contacts the treatment deemed necessary by:

Dr._____**at** _____

(Name of Physician) (Phone)

Dr._____**at**_____

(Name of Dentist) (Phone)

The transfer of child to (Preferred Hospital)_____

My health insurance carrier is_____**Policy/Group#**_____

The following include condition(s) and/or medications may be taking and any other facts to which a physician or dentist should be aware of.

Name of Child **Condition** **Medication(s)**

_____

_____

_____

Parent / Guardian Signature_____**Date**_____

Refuse to Consent to Emergency Medical Care I do NOT give my consent for emergency medical treatment of my child. I do, however, wish to be contacted if any such emergency shall occur.

Parent/Guardian Signature_____**Date**_____